STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Before the Director of the Department of Insurance and Financial Services

In the matter of:

Prescribed Therapy
Petitioner **File No. 21-1708**

v

Auto Club Group Insurance Company
Respondent

Issued and entered
this 17th day of February 2022
by Sarah Wohlford
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On November 9, 2021, Prescribed Therapy (Petitioner) filed with the Department of Insurance and Financial Services (Department) a request for an appeal pursuant to Section 3157a of the Insurance Code of 1956 (Code), 1956 PA 218, MCL 500.3157a. The request for an appeal concerns the determination of Auto Club Group Insurance Company (Respondent) that the cost of treatment, products, services, or accommodations that the Petitioner rendered was inappropriate under Chapter 31 of the Code, MCL 500.3101 to MCL 500.3179.

The Petitioner's appeal is based on the denial of a bill pursuant to R 500.64(3), which allows a provider to appeal to the Department from the denial of a provider's bill. The Respondent issued the Petitioner a bill denial on August 20, 2021. The Petitioner now seeks reimbursement in the full amount it billed for the dates of service at issue.

The Department accepted the request for an appeal on November 17, 2021. Pursuant to R 500.65, the Department notified the Respondent and the injured person of the Petitioner's request for an appeal on November 17, 2021 and provided the Respondent with a copy of the Petitioner's submitted documents. The Respondent filed a reply to the Petitioner's appeal on December 7, 2021.

II. FACTUAL BACKGROUND

This appeal concerns the appropriate reimbursement amount for home health services rendered on 16 dates of service[1] under Healthcare Common Procedure Coding System (HCPCS) Level II code G0156, which is described as home health aide, in a home health or hospice setting, each 15 minutes.

With its appeal request, the Petitioner submitted documentation that included an *Explanation of Review* letter issued by the Respondent, its 2019 charge description master (CDM), and a narrative outlining its reason for appeal. The Petitioner stated in its narrative that the "[Respondent] is not Medicare, nor are they are Medicare intermediary and cannot require Medicare provider requirements on a no-fault case."

Additionally, the Petitioner's request for appeal stated:

> Denial reasons (X773, X8074) requires provider to have a Medicare Provider ID and use specific Medicare Health Insurance Prospective Payment System (HIPPS) code, and Revenue code 0023 which indicates a Medicare Request for Anticipated Payment (RAP) which is counter to the law and information on the DIFS website, as being a Medicare provider is not required for payment under no-fault. [The Respondent] has paid [the Petitioner] at their chargemaster rate for this same [injured person] for these same services since inception of this case in 2014. [The Respondent] entered into a contract with [the Petitioner] with terms being payment at 99% of [the Petitioner's] gross charges.

In its denial, the Respondent requested that the Petitioner resubmit its bill with appropriate information and stated that a "Medicare Provider ID Number is required to process this bill/service." The Respondent further stated that "CMS requires home health to be billed with Revenue Code 0023 and a [Health Insurance Prospective Payment System] Code." In its reply, the Respondent stated that the Petitioner's bill was re-reviewed and paid accordingly to the CDM that was submitted by the Petitioner.

Specifically, the Respondent stated:

> Following receipt and review of the Appeal filed by [the Petitioner], our December 8, 2021 denial relating to dates of service July 2, 5, 6, 7, 8, 9, 12, 13, 14, 15, 16, 19, 20, 21, 22, 23, 2021 was reconsidered based on verification of the January 1, 2019 CDM charges and corrected for payment…Payment was issued with interest for dates of service July 2, 5, 6, 7, 8, 9, 12, 13, 14, 15, 16, 19, 20, 21, 22, 23, 2021.

On November 23, 2021, the Department requested the Petitioner submit its CDM. See MCL 500.3157(7). The Petitioner responded and submitted its CDM to the Department on November 24, 2021.

[1] The dates of service at issue are: July 2, 5, 6, 7, 8, 9, 12, 13, 14, 15, 16, 19, 20, 21, 22, and 23, 2021.

III. ANALYSIS

Director's Review

Under MCL 500.3157a(5), a provider may appeal an insurer's determination that the provider overutilized or otherwise rendered inappropriate treatment, products, services, or accommodations, or that the cost of the treatment, products, services, or accommodations was inappropriate under Chapter 31 of the Code. This appeal involves a dispute regarding cost.

For dates of service after July 1, 2021, MCL 500.3157 governs the appropriate cost of treatment and training. Under that section, a provider may charge a reasonable amount, which must not exceed the amount the provider customarily charges for like treatment or training in cases that do not involve insurance. Further, a provider is not eligible for payment or reimbursement for more than specified amounts. For treatment or training that has an amount payable to the person under Medicare, the specified amount is based on the amount payable to the person under Medicare. If Medicare does not provide an amount payable for a treatment or rehabilitative occupational training under MCL 500.3157(2) through (6), the provider is not eligible for payment or reimbursement of more than a specified percentage of the provider's charge description master in effect on January 1, 2019 or, if the provider did not have a charge description master on that date, an applicable percentage of the average amount the provider charged for the treatment on January 1, 2019. Reimbursement amounts under MCL 500.3157(2), (3), (5), or (6) may not exceed the average amount charged by the provider for the treatment or training on January 1, 2019. See MCL 500.3157(8); MAC R 500.203.

MCL 500.3157(15)(f) defines "Medicare" as "fee for service payments under part A, B, or D of the federal Medicare program established under subchapter XVIII of the social security act, 42 USC 1395 to 1395lll, without regard to the limitations unrelated to the rates in the fee schedule such as limitation or supplemental payments related to utilization, readmissions, recaptures, bad debt adjustments, or sequestration." Under MAC R 500.203, reimbursements payable to providers are calculated according to "amounts payable to participating providers under the applicable fee schedule." "Fee schedule" is defined by MAC R 500.201(h) as "the Medicare fee schedule or prospective payment system in effect on March 1 of the service year in which the service is rendered and for the area in which the service was rendered." Accordingly, reimbursement to providers under MCL 500.3157 is calculated either on a fee schedule (i.e., fee-for-service) basis or on a prospective payment system basis.

HCPCS Level II Code G0156 has an amount payable under Medicare when it is billed on a prospective payment system basis. No payment amount is available for HCPCS Level II Code G0156 under on a fee-schedule basis because that code is not priced separately. Where there is no amount payable under Medicare, reimbursement is calculated based on a provider's charge description master or average amount charged on January 1, 2019. See MCL 500.3157(7).

To calculate the appropriate reimbursement amount, the Department relied on the Petitioner's submitted CDM as of January 1, 2019 for G0156. Pursuant to MCL 500.3157(7), the amount payable to the Petitioner for the procedure code and dates of service at issue is listed in the table below:

HCPCS code	January 1, 2019 charge description master amount	55% of January 1, 2019 charge description master amount	4.11% CPI Adjustment	Amount payable for the dates of service at issue
G0156	$[redacted]/hour[2]	$[redacted]	$[redacted]	$[redacted]/hour

Accordingly, the Department concludes that the Petitioner is not due additional reimbursement for the services and dates of service at issue.

IV. ORDER

The Director upholds the Respondent's determination dated December 17, 2021.

This order applies only to the treatment and dates of service discussed herein and may not be relied upon by either party to determine the injured person's eligibility for future treatment or as a basis for action on other treatment or dates of service not addressed in this order.

This is a final decision of an administrative agency. A person aggrieved by this order may seek judicial review in a manner provided under Chapter 6 of the Administrative Procedures Act of 1969, 1969 PA 306, MCL 24.301 to 24.306. MCL 500.244(1); R 500.65(7). A copy of a petition for judicial review should be sent to the Department of Insurance and Financial Services, Office of Research, Rules, and Appeals, Post Office Box 30220, Lansing, MI 48909-7720.

Anita G. Fox
Director
For the Director:

X Sarah Wohlford

Sarah Wohlford
Special Deputy Director
Signed by: Sarah Wohlford

[2] The Petitioner's CDM listed an hourly charge of $55.00 per hour for G0156, which it described as "Home Health Aide, each 60 minutes." Under the HHPPS, G0156 is billed in 15-minute increments, so for purposes of this review, the Department relies on the description of the services, not the code appended to that description.